

Figure 1

Patient Description:	45 y/o male with TAA presenting on 7/20/02 with atypical chest pain
HPI:	Presented to Sentara Beach with c/o atypical CP. Dx. with TAA, 12.5cm x 6.9 x 2.7, involving the renal arteries. Cardiac clearance for OR by nuclear stress scan - nl LV fx, small area of apical ischemia
Source of Pt Info:	medical records
Pre-Admission Meds:	aspirin, other, other, other, other
Allergies:	Penicillin
Past History:	CVASC: HTN, hypercholesterolemia; PULM: COPD, asthma; GI: hernia repair x 2
Review of Systems:	CVASC: chest pain - atypical; PULM: denies COPD, denies bronchitis; ENDO: negative; MUSC: SKEL: negative
Social History:	Occupation: sales; married; ethanol use: rare; 20-40 pack years - still smoking; DRUG ABUSE: no
Family History:	CAD: father; cancer: sister has polycystic disease
Physical Exam:	HR: 62, sinus, with PACs; BP: 120/80; Tmax: 38.5; Resp: 20, stridorous; O2 sat: 92; FIO2: 60; PEEP: 20 CVP: 12; PAOP: 17; CO: 4.5; SVR: 1280 Healthy appearing; obese; not in acute distress NEURO: GCS: M-6, V-5, E-4; mental status: sedated, agitated at times, oriented x 3 Head/neck: pupils: equal, react to light; conjunctivae: normochemosis; ear: normal; mouth/pharynx: edentulous, small palatal erosion; neck: normal mobility, no tenderness, no JVD PULM: not intubated; clear to percussion; bibasilar rales CVASC: PMI: normal; S-1 normal, S-2 normal, no S-3, no S-4; no murmurs, ruburs; L carotid decreased GI: within normal limits EXTREM: perfusion: adequate
Test Results:	eggs - 3.2, Hct - 29, WBC - 13.9, Plt - 196, INR - 1.56, PTT - 58 Na - 134, K - 3.5, Cl - 103, HCO3 - 24, BUN - 22, Glu - 220, Ca - 8.2, Cr - 1.5, Phos - 4.4, Mg - 1.0, Albumin - 0.5, Total Protein - 4.0, AST (SGOT) - 22, ALT (SGPT) - 12, LDH - 98, Total Bilirubin - 2.2 Digoxin - 1.8, Theophylline - 12 pH - 7.56, PCO2 - 32, PO2 - 113, HCO3 - 19, vented, FIO2 - 50%, PEEP 5
Assessment and Plan:	
NEURO	Problems: encephalitis-viral (hepat)
CVASC	Problems: chest pain-atypical, aortic aneurysm, hypertension Treatment: beta-blocker, oxygen therapy (<40%) TAA - for OR Monday, on BNP and Ipratropium, needs beta-blocker postop. Low risk coronary per nuclear scan. Active smoker w/ no known symptoms, flu CPR, bronchodilators postop. 500mg DVT / GI prophylaxis / nutritional support

Figure 2

Microsoft Internet Explorer

Patient: 2411 MC Elected Mfile: 22456730 Center: North General Hospital Age: 44 Gender: Male

Patient Profile	Vital Signs	Event Log	Laboratory	Imaging	Medications	Orders/Orders	Notes/Notes	Physician/Physician	The Bridge
Care Plan	Flowchart	Life Log	Microbiology	ABQ/Ment	Medication	Order View	Notes View	Physician	

Create Admission Note

Was the patient admitted from the O.R. or went to O.R. within 4 hours of admission? ☐ No ☒ Yes

Admission Diagnosis:

Organ System: Diagnosis:

Chief Complaint/History of Present Illness

44 yo male presented with 5/10/2016 after admission of abdominal pain at home. 44 yo male presented with 5/10/2016 after admission of abdominal pain at home. 44 yo male presented with 5/10/2016 after admission of abdominal pain at home.

Source of Patient Information:

Screen 1 of 10

Figure 3

Patient Chart: Microsoft Internet Explorer
 Project Center Refresh Task List Change Patient

(41) Mr. Ercan, M-#12440000, peritoneal dialysis, hepatic, renal, 44, male, 170cm

Patient Profile Vital Signs Event Log Laboratory Land O Medication Orders Create My Images The Source
 Care Plan Flowsheet Use Log Microbiology ABQ/Ven Meds Update Orders View My Reports

Create Admission Note

Was the patient admitted from the O.R. or went to O.R. within 4 hours of admission? ☒ Yes ☐ Elective ☐ No

-Surgical Diagnosis
 Organ System: Cardiovascular ☒ Diagnosis: Aneurysm, abdominal aortic with rupture

Post-Operative Status:
 Anesthesia: General ☒ EBL (ml): 150

Complications:
☐ Cardiac Arrest ☐ Hypotension ☐ Myocardial Ischemia
☒ Difficult Intubation ☐ Massive Hemorrhage ☐ Prolonged Hypotension

Fluids:
 Cell Saver (ml): 500 FFP (units): 0
 Colloid (ml): 0 Platelets (units): 0
 Crystalloid (ml): 500 PRBC (units): 4

Chief Complaint/History of Present Illness:
 64 yo male presented with hypertension after complaining of abdominal pain at home. Pt with known AAA - stable for the past 2 years.

Source of Patient Information: Emergency Room

Screen 1 of 10
 Cancel New

● Indicates a required field

Figure 4

Create Admission Note

Allergies (Yes)
☒ **List of Drug Allergies**
☐ **List of Non-Drug Allergies**

Drug Name	Dosage	Unit	Frequency	Onset
PENICILLIN SODIUM	250	mg	q4	2500
SULFAMETHOXAZOLE	10	mg	q4	2500

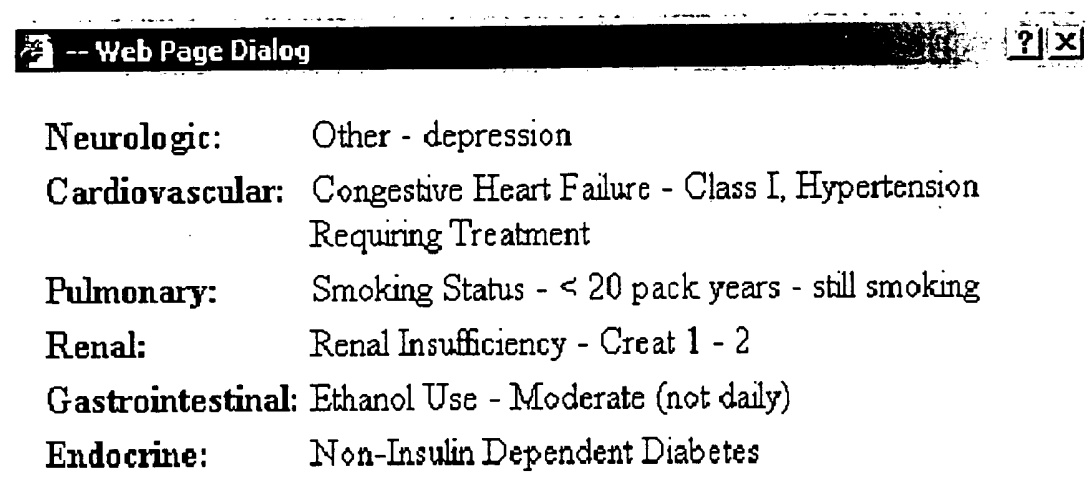
Pre-Admission Medications (Yes)
☒ **List of Pre-Admission Medications**

Drug Name	Dosage	Unit	Frequency	Onset
LASIX	20	mg	q4	2500
GLUCOTROL XL	10	mg	q4	2500
AMLODIPINE BESYLATE	10	mg	q4	2500
PAKL	20	mg	q4	2500

Figure 5

Figure 6

FIGURE 7




A screenshot of a web browser window titled "Web Page Dialog". The window contains a list of medical conditions organized by system. The conditions are: Neurologic: Other - depression; Cardiovascular: Congestive Heart Failure - Class I, Hypertension Requiring Treatment; Pulmonary: Smoking Status - < 20 pack years - still smoking; Renal: Renal Insufficiency - Creat 1 - 2; Gastrointestinal: Ethanol Use - Moderate (not daily); Endocrine: Non-Insulin Dependent Diabetes.

Neurologic:	Other - depression
Cardiovascular:	Congestive Heart Failure - Class I, Hypertension Requiring Treatment
Pulmonary:	Smoking Status - < 20 pack years - still smoking
Renal:	Renal Insufficiency - Creat 1 - 2
Gastrointestinal:	Ethanol Use - Moderate (not daily)
Endocrine:	Non-Insulin Dependent Diabetes

FIGURE 8

Patient History		Review		Task Log		Current Encounter		Notes	
Patient Profile	Vital Signs	Event Log	Laboratory	Test ID	Medications	Orders-Care	Immunization	Key Findings	The Source
Care Plan	Race/Ethnicity	Last Log	Miscellaneous	ABQ/Ment	Medications	Orders-View	Notes-View	View Reports	
Create Admission Note									
Review Of Systems									
* Performed * Not Performed									
General Systemic									
Weight Loss: [Not Performed]									
Fever: [Not Performed]									
Comments:									
Eye									
Blurred vision: [Not Performed]									
Double vision: [Not Performed]									
Eye pain: [Not Performed]									
Comments:									
ENT									
Hearing problems: [Not Performed]									
Tinnitus: [Not Performed]									
Comments:									
Cardiovascular									
Chest pain: [Not Performed]									
Palpitations: [Not Performed]									
Leg swelling: [Not Performed]									
Comments:									
Respiratory									
Shortness of breath: [Not Performed]									

Cancel Next >>

<div>  -- Web Page Dialog </div>	<div>   </div>
<div> <div>Cardiovascular</div> <div>Neurologic</div> <div>Psychiatric</div> </div>	<div> <div>Leg swelling;</div> <div>Loss of consciousness;</div> <div>Depression;</div> </div>

Patient Census		Refresh		Task List		Change Password		Logout	
BT-4) Randal Cunningham		MR#321654687		VISICU : Guest Facility (-300 GMT) : GICU		Age: 38		Gender: Male	
Fishers Rules		Insurance Data	Update Medications	Laboratory	Lab Orders/History	Medications	Order Entry	Order Review	Order Print
Care Plan		Event Log	Respiratory	Use Log	Land O	Imaging	Order Review	Notes View	The Source

Create Admission Note

Social History

☐ Performed ☐ Not Performed

Occupation:

Hobbies:

Marital Status:

Smoking Status:

Ethanol Use:

IV Drug Abuse:

Other Medic Drugs:

Recent Travel:

Comments:

Family History

☐ Performed ☐ Not Performed

CAD:

Cancer:

Bleeding Disorders:

Comments:

Screen 5 of 10
● Indicates a required field.

cc: [button]
[button]
[button]

FIGURE 11

Patient Demographics		Physician		Topic List		Change Parameters		Locales	
SAM	MAR	MR	MR	MR	MR	MR	MR	MR	MR
Review Profile	Vital Signs	Event Log	Laboratory	Imaging	Medications	Order Entry	Patient History	Physician History	Physician
Care Plan	Radiology	Unit Log	Monitoring	ADLs	Nutrition	Outlook View	Notes View	Navigation	Print Screen

Create Admission Note

Physical Exam

- Performed - Not Performed

Signs/Symptoms Summary 1 - Constitutional 2 - Neurologic 3 - Eyes 4 - Ear/Nose/Mouth/Throat 5 - Neck 6 - Respiratory 7 - Cardiovascular 8 - Abdominal/Hernia/Dynamic Data 9 - Genitourinary 10 - Skin	Constitutional	
	- Vital Sign Data	
	Non-invasive Meas:	F/A
	Systemic Meas:	F/A
	PA Meas:	F/A
	Heart Rate:	F/A
	Rhythm:	[Normal] [Abnormal]
	Temp (axil):	F/A
	Comments:	
	Appearance	
General well-being:	[Good] [Poor]	
Acute distress:	[No] [Yes]	
Nutritional status:	[Good] [Poor]	
Comments:		
Neurologic		
GCS:		
Motor Score:	[3] [4] [5] [6] [7] [8] [9] [10]	
Verbal Score:	[3] [4] [5] [6] [7] [8] [9] [10]	
Eyes Score:	[3] [4] [5] [6] [7] [8] [9] [10]	
Mental Status:		
Level of consciousness:	[Alert] [Drowsy] [Comatose]	
Mood:	[Happy] [Sad] [Angry] [Calm]	
Oriented:	[Person] [Place] [Time]	
Comments:		

FIGURE 12

<p>Organ System</p> <ul style="list-style-type: none"> • Nervous • Musculoskeletal • Endocrine • Cardiovascular • Skin • Hematologic • Urinary System • Gastrointestinal • Respiratory • Reproductive • Integumentary • Sensory 	<p>Organ System</p> <ul style="list-style-type: none"> • Nervous • Musculoskeletal • Endocrine • Cardiovascular • Skin • Hematologic • Urinary System • Gastrointestinal • Respiratory • Reproductive • Integumentary • Sensory
Today's problems diagnoses:	Today's treatments diagnostics:
<input type="button" value="Check All"/> <input type="button" value="Remove Unchecked"/>	<input type="button" value="Check All"/> <input type="button" value="Remove Unchecked"/>
<p>If the data observed does not fit, select:</p>	
<input type="button" value="Previous"/>	<input type="button" value="Next"/>

FIGURE 13

Emergency Room Information

Return Task Log Cancel Print

MRN: MF000000 MF00000000 To: Dr. J. D. F. Patient Number: 001

6/1/01 09:30 AM

Patient Profile	Vital Signs	Event Log	Laboratory	Test O	Medications	Orders-Cases	Lab Orders	Key-Info	The Source
Case Plan	Runsheet	Lab Log	Microbiology	ABQ Menu	Mediupdate	Orders View	A. Notes View	Key Reports	

Create Admission Note

Laboratory Results To Print:

☐ Chemistry ☐ ABQ ☐ CBC & Coagulation ☐ Drug Levels ☐ Cardiac/Metabolic Levels

Assessment and Plan:

Patient appears to be moderately agitated, disoriented, with moderate fluid overload and moderate risk for rapid deterioration. Patient's pulse per minute is 100.

Screen 0 of 1

Cancel

● indicates a required field

Next >>

FIGURE 14[illegible]

FIGURE 15

[illegible]

FIGURE 16

Patent Chart - Microsoft Internet Explorer

Refresh Task List Change Password Logout

2411 MB Election LF#123456789 Setera (Admit) Current History ICU Age 44 Gen Gender

Person Profile	Vital Signs	Event Log	Laboratory	Isand D	Medications	Orders-Create	Phys. Orders	Body Images	The Route
Care Plan	Flowchart	Line Log	Medication	ABC View	Medication	Orders-View	Phys. Orders	Body Images	

Create Re-Admission Note

Reason for Readmission? ●

Was the patient admitted from the O.R. or went to O.R. within 4 hours of admission? ●

- Admitting Diagnoses

Organ System ● Diagnosis ●

Chief Complaint/History of Present Illness:

At 70 was the recent ruptured AAA repair that included return to OR for drainage of hematoma. Over past several days, has developed fever, cough and purulent sputum, CXR reveals RLL infiltrate and brought to ICU for increasing respiratory distress.

Source of Patient Information ●

Screen 1 of 10

Cancel

● indicates a required field

Next >>

FIGURE 17

Patient Care		Referral		Task List		Change Parameters		Logout	
Adm	Vital Signs	Event Log	Laboratory	I and O	Medication	Orders-Create	Orders-View	Physician	The Source
Case Plan	Flow Sheet	Use Log	Microbiology	ABX/Hist	Meds Update	Orders-New	Notes View	New Orders	

Create Re-Admission Note

Reason for Readmission? ☐ New medical problem ☒

Was the patient admitted from the O.R. or went to O.R. within 4 hours of admission? Yes ☐ Elective No ☒

Surgical Diagnosis _____

Organ System ☐ Cardiovascular ☒ Diagnostics [SAGE score consistently above normal] _____

Post-Operative Status: _____

Anesthesia General ☒ EBL (ml) 500

Complications: <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Hypotension <input checked="" type="checkbox"/> Myocardial Ischemia <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Massive Hemorrhage <input type="checkbox"/> Prolonged Hypertension	Fluids: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Cell Saver (ml)</td> <td>0</td> <td>FFF (units)</td> <td>0</td> </tr> <tr> <td>Colloid (ml)</td> <td>500</td> <td>Platelets (units)</td> <td>0</td> </tr> <tr> <td>Crystalloid (ml)</td> <td>1500</td> <td>pFEC (units)</td> <td>0</td> </tr> </table>	Cell Saver (ml)	0	FFF (units)	0	Colloid (ml)	500	Platelets (units)	0	Crystalloid (ml)	1500	pFEC (units)	0
Cell Saver (ml)	0	FFF (units)	0										
Colloid (ml)	500	Platelets (units)	0										
Crystalloid (ml)	1500	pFEC (units)	0										

Chief Complaint/History of Present Illness:

At 10 am on recent evening received call reports that included return to CC for drainage of hematomas over past several days. has developed chest pain associated with tachycardic ECG changes. cardiac cath revealed severe triple vessel disease and patient received 3 vessels CABG. Intraoperative course notable for onset of myocardial ischemia during anesthetic induction that resolved with the administration of nitroglycerin and beta blockers.

Source of Patient Information ☐ Verbal/German ☒

Screen Lock ID
● Indicates Required Field

Cancel
Next >>

FIGURE 18

Create Comprehensive Progress Note

Has the patient had surgery since the last progress Note? ☐ No ☒ Yes

Events of Note:

Screen 1 of 3

● indicates a required field

FIGURE 19

3001	1000000000	1000000000	1000000000	1000000000	1000000000	1000000000	1000000000	1000000000	1000000000	1000000000	1000000000
Patient Profile	Vital Signs	Event Log	Laboratory	Imaging	Medications	Orders-Created	Orders-Active	Orders-Expired	Orders-Expired	Orders-Expired	Orders-Expired
Demographics	Flowchart	Life Log	Microbiology	ADG/Verif	Medi-update	Orders-Active	Orders-Expired	Orders-Expired	Orders-Expired	Orders-Expired	Orders-Expired

Create Comprehensive Progress Note

Has the patient had surgery since the last progress Note? ☒ Yes ☐ No

Surgical Diagnosis
Organ System: Cardiovascular **Diagnosis:** Coronary artery disease, myocardial infarction, congestive heart failure, etc.

Post-Operative Status:
Arrest/Resuscitation: ☒ EBL (ml) (mm)

Complications:

<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Pulmonary	<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Difficult Ventilation	<input type="checkbox"/> Massive Hemorrhage	<input type="checkbox"/> Prolonged Hypotension

Fluids:

Crystalloid (ml)	0	FFP (units)	0
Colloid (ml)	0	Platelets (units)	0
Crystalloid (ml)	0	LRPC (units)	0

Events of Note:

Patient placed on ventilator, hypotension and increasing abdominal distention with oliguria and was brought back to operating room for re-exploration which revealed a hematoma due to a small tear at the graft anastomosis line. It remained in stable condition to the ICU.

Screen 1 of 1

● indicates a required field

FIGURE 20

Patient Census		Refresh		Task List		Change Password		Logout	
MD Elisha		MR#123456789		Sentara Norfolk General Hospital		App: 44		Gender: M	
Patient Profile	Vital Signs	Event Log	Laboratory	I and O	Medication	Orders-Creat	Physiologic	X-ray Images	The Source
Core Plan	Flowchart	Line Log	Microbiology	ABQ/Vent	Medi-Update	Orders-New	Medi-View	X-ray Reports	

Create Brief Progress Note

Sentara
Norfolk General Hospital
MR# 123456789

Brief Progress Note
PERMANENT
3/3/2002 3:33

Events of Note:

Lachyonda noted on smart alert, moderate hypotension then noted on vital signs review as well as a decrease in CVP. By video examination, patient is in no distress, most recent electrolytes are normal, case discussed with ICU RN and will administer a bolus of 500 ml's normal saline and reassess

Electronically signed by

FIGURE 21

Patient Chart - Create Procedure Note

Edit Format Tools Window Help

Patient Profile Vital Signs Exam Log Laboratory I and O Medications Orders/Orders Patient Orders X-ray Images The Source

Create Procedure Note

Procedure: Catheterization Type of catheter:

- Arterial
- Cuffed
- Double-lumen
- Endotracheal
- Foley

Cancel

FIGURE 22

Report Header: Patient Information

Procedure: Catheterization Type of Catheter: Central Venous

Location: [Left Iliac Vein] Indication: [for assessment of intravascular volume]

Sub-Type: [Multiple Lines] [Peripheral Venous Catheter]

Technical Description:

☒ Procedure performed with gown and sterile technique ☒ Local anesthetic administered

☒ Seldinger technique used [Fluoroscopy] [Ultrasound]

Evaluation:

Blood flow: [good]

CXR: [normal]

Complications: [No adverse complications]

Miscellaneous Information:

[Empty text area]

Screen: 1/1 [Cancel] [Print as given] [Next >>]

FIGURE 23

Patient Chart - Information Management										Logout	
Print Chart		Refresh		Track List		Change Password					
3411 - NCD 00000		MR 01/24/97		General - DRUG Orders Received - 0000				Page 11		Order Menu	
Patient Profile	Vital Signs	Event Log	Laboratory	Imaging	Medications	Orders-Created	Orders-Open	Orders-Main	Orders-Print	Orders-Delete	Orders-Export
Case Plan	Flowchart	Use Log	Monitoring	ABC/Vent	Medication Update	Orders-New	Orders-New	Orders-New	Orders-New	Orders-New	Orders-New

Create Procedure Note											
<p>Location:</p> <p>North Central Hospital</p> <p>MR - Inpatient MR 12/24/97</p>										<p>Procedure Note</p> <p>PERMANENT</p> <p>5/2/97 4:00</p>	
<p>Procedure: Central venous catheter insertion</p> <p>Description of Procedure: multiple lumen antineoplastic bonded coated Central venous catheter inserted into left subclavian vein for assessment of intravascular volume. No catheter inserted. Procedure performed with gown and sterile technique. Local anesthetic administered, Seldinger technique used, blood flow good, CXR normal. CXR No apparent complications.</p> <p style="text-align: right;">Electronically signed by</p>											

Screen Size 2		<input checked="" type="radio"/> Print (4x6) (4x6) (4x6)		<input type="checkbox"/> Sign As: Username		Password		<input checked="" type="radio"/> Print	
Previous		Cancel		Save		Print and Save			

FIGURE 24[illegible]

Table 1

Chemistries	ABG	CBC and Coagulation	Drug Level	Cardiac/Metabolic Levels
Na	pH	Hgb	NAPA (mcg/mL)	CPK (U/L)
Cl	PCO2	WBC	Tacrolimus-FK506 (ng/mL)	CPK-MB (%)
BUN	PO2	INR	Acetaminophen (mcg/mL)	CPK-MB (U/L)
Glu	HCO3	Hct	Amikacin (mcg/mL)	TSH (uU/mL)
Ca	RO2	Plts	Carbamazepine (mcg/mL)	Ammonia (uM/L)
K	PEEP	PTT ratio	Cyclosporin (ng/mL)	Cortisol (mcg/dL)
HCO3			Digoxin (ng/mL)	Ketones
Cr			Gentamicin (mcg/mL)	Osmolality (mOsm/kg H2O)
Phos			Lidocaine (mcg/mL)	Triglycerides (mg/dL)
Mg			Lithium (mEq/L)	Troponin - I (mcg/L)
Albumin			Phenobarbital (mcg/mL)	Troponin - T (mcg/L)
Total Protein			Phenytoin (mcg/mL)	
AST (SGOT)			Procainamide (mcg/mL)	
ALT (SGPT)			Theophylline (mcg/mL)	
LDH			Tobramycin (mcg/mL)	
Total Bilirubin			Vancomycin (mcg/mL)	
Direct Bilirubin				
Amylase			Tacrolimus-FK506 (ng/mL)	
Lactate			Acetaminophen (mcg/mL)	
Alkaline Phos				